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Health Care Reform: General Q&A for Employees

Common questions answered

I've heard a lot about the health care reform law. When do the reforms become effective? The health care reform bill was signed into law in March 2010. The changes made by the health care reform law go into effect over a period of years. Some of the law's changes are already in effect, such as the prohibition on pre-existing condition exclusions for individuals under age 19. Other key changes go into effect in 2014, such as the requirement for individuals to buy health coverage or pay a penalty.

Does health care reform allow people to keep their current health coverage?

Yes. Nothing in the law requires individuals to terminate coverage that they had on the date the law was passed. However, due to new coverage requirements, the coverage provided under an individual's plan may change. Also, employers are not required to offer the same coverage in future years.

If an employer's health plan existed on March 23, 2010, and the employer has not made certain changes to the plan, the plan may have grandfathered status. Grandfathered plans are subject to many, but not all, of the health care reform law's requirements.

In 2014, most U.S. citizens must obtain health insurance coverage or they will be subject to penalties, with exceptions for low-income individuals and those unable to obtain affordable coverage.

Are individuals required to have health coverage? Starting in 2014, most individuals will be required to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. This provision of the health care reform law is often called the "individual mandate" because it has the effect of requiring individuals to have health coverage.

If you are covered under a health plan offered by your employer, or if you are currently covered by a government program such as Medicare, you can continue to be covered under those programs.

Who is exempt from the individual mandate? Certain individuals are exempt from the individual mandate. For example, you may be exempt from the penalty for not maintaining acceptable health coverage if you:

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Cannot afford coverage (that is, the required contribution for coverage would cost more than 8 percent of your household income)

Have income below the federal income tax filing threshold

Are not a citizen, national or lawfully present in the United States

What are the penalties for individuals who don't have health coverage? The penalty for not obtaining acceptable health coverage will be phased in over a three-year period. The amount of the penalty is the greater of two amounts—the “flat dollar amount” and “percentage of income amount.”

2014: The penalty will start at \$95 per person or up to 1 percent of income.

2015: The penalty increases to \$325 per person or up to 2 percent of income.

2016 and after: The penalty increases to \$695 per person or up to 2.5 percent of income.

The penalty for a child is half of that for an adult. The penalty is calculated on a monthly basis, and will be assessed for each month in which an individual goes without coverage. There is no penalty for a single lapse in coverage lasting less than three months in a year.

Does the law affect health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) and health savings accounts (HSAs)? As of Jan. 1, 2011, the costs of over-the-counter medications can be reimbursed under a health FSA, HRA or HSA only if the medications are purchased with a doctor's prescription. This restriction does not apply to the purchase of insulin.

Effective for 2013, there is an annual cap of \$2,500 on employee pre-tax contributions to health FSAs. (The health care reform law does not change the limit on dependent care accounts, which remains capped at \$5,000.) Also, if you are under age 65 and you withdraw money from your HSA for a purpose other than a qualified medical expense, you will be subject to an additional excise tax of 20 percent (up from 10 percent).

How long can my adult child remain covered under my health plan? Health plans are required to permit children to stay on family coverage until they turn 26. This rule applies to all plans in the individual market and to non-grandfathered employer plans. It also applies to grandfathered employer plans; however, the



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sponsor of a grandfathered plan may decide to exclude from coverage adult children with another offer of employer-based coverage (such as through the child's job). Beginning in 2014, grandfathered plans must cover children up to age 26, even if they have another offer of coverage through an employer. Note that state law requirements may require offering coverage beyond age 26.

Is the coverage for my adult dependent taxable? No, the value of the coverage is not subject to federal tax for the employee or dependent. The health care reform law revised the Internal Revenue Code to clarify that the cost of coverage for a taxpayer's child is excluded from income through the end of the year in which the child turns 26.

Can I get coverage for my pre-existing condition? Health plans cannot deny benefits or limit coverage for a child under the age of 19 because the child has a pre-existing condition (that is, a health problem that developed before the child applied to join the plan). Effective for plan years beginning on and after Jan. 1, 2014, health plans cannot impose pre-existing condition exclusions on any enrollees. This applies to all non-grandfathered and grandfathered plans.

Prior to 2014, is there a special coverage option for individuals with pre-existing conditions? The health care reform law created a federal pre-existing condition insurance plan (PCIP) for individuals with pre-existing conditions who had been uninsured for at least six months. This was a temporary program and, due to funding limitations, it stopped accepting new enrollment applications as of Feb. 16, 2013. However, beginning in 2014, health plans will not be able to impose pre-existing condition exclusions on any enrollees.

Are my health benefits subject to lifetime or annual limits? The health care reform law prohibits health plans from placing lifetime limits on most benefits. A lifetime limit is the dollar amount on what the plan would spend for your covered benefits during the entire time you were enrolled in the plan.

The law restricts the annual dollar limits that health plans can put on most covered benefits. For plan years starting on or after Sept. 23, 2012, but before Jan. 1, 2014, the restricted annual limit is \$2 million. Effective for plan years beginning on or after Jan. 1, 2014, no annual limits are allowed on most covered benefits.

Can my health plan or insurance company terminate my coverage if I get sick? Health plans and insurance companies are prohibited from retroactively dropping, or rescinding, your coverage when you get sick. Also, your coverage cannot be retroactively canceled solely because you or your employer made an honest mistake on your insurance application. Rescissions of coverage are allowed only in cases of



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fraud or material misrepresentation. This rule applies to all non-grandfathered and grandfathered plans.

Is my plan required to provide free preventive care? All non-grandfathered group health plans and plans in the individual market must provide coverage for recommended preventive health services. If your plan is subject to this requirement, you should not have to pay a copayment, co-insurance or deductible to receive recommended preventive health services – such as screenings, vaccinations and counseling.

For example, depending on your age, you may access (at no cost) to preventive services such as:

Blood pressure, diabetes and cholesterol tests

Many cancer screenings, including mammograms and colonoscopies

Regular well-baby and well-child visits, from birth to age 21

Routine vaccinations against diseases such as measles, polio or meningitis

If your plan is grandfathered, these benefits may not be available to you. Also, if your health plan uses a network of providers, these benefits may only be available through a network provider. Your plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.

In addition, effective for plan years beginning on or after Aug. 1, 2012, non-grandfathered health plans must provide additional preventive services for women without cost sharing, such as coverage for well woman visits, breastfeeding support and contraception. Exceptions to the contraceptive coverage requirement apply to religious employers.

How does the health care reform law make insurance companies more accountable for how they spend premium dollars? Health insurers, including insurers of grandfathered plans, must annually report on what percentage of premium dollars they spend on medical care, as opposed to profits, marketing and administrative expenses. You can see that information online and may be entitled to a rebate if your plan spent too much on overhead and profits. Health insurers must also post information about some rate increases along with a justification for them.

This information is available at: www.healthcare.gov.



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Did the health care reform law eliminate COBRA? No. The health care reform law did not eliminate COBRA or change the COBRA rules.

How does the health care reform law help me learn more about my health plan coverage?

Under the health care reform law, your health insurance company or group health plan is required to provide you with an easy-to-understand summary about benefits and coverage. This requirement is designed to help you better understand and evaluate your health coverage choices. This summary is called a Summary of Benefits and Coverage, or SBC. You may also request a glossary of terms from your health plan or health insurer. The glossary includes definitions for commonly used terms in health insurance coverage, such as "deductible" and "copayment."

Also, your Form W-2 may include information on the total cost of employer-sponsored health coverage. This information is provided to let you know how much your coverage costs. It does not mean that the cost of coverage is taxable to you. If your employer filed fewer than 250 W-2 Forms last year, it was not required to provide this information on your Form W-2.

What is the new health insurance exchange, or Marketplace, and when will it be available?

The health insurance exchange is an online marketplace that is designed to help make buying health coverage easier and more affordable. Effective for 2014, the Marketplace will allow individuals and small businesses to compare health plans, get answers to questions and find out if they are eligible for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP) and enroll in a health plan that meets their needs.

When will I be able to enroll in a health plan through the new Marketplace? The initial enrollment period for the Marketplace will begin on Oct. 1, 2013. Starting in October 2013, you will be able to get information from the Marketplace about the plans in your area. You will be able to enroll directly through the website or by calling a toll-free phone hotline. If you are having difficulty finding a plan that meets your needs and budget, there will be people available to help. These helpers will not be associated with a particular plan and will not receive any type of commission, so the help they provide will be unbiased. Your coverage through the Marketplace would begin as early as Jan. 1, 2014.



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Will I receive more information about the Marketplace? You should receive a notice about the Marketplace from your employer by Oct. 1, 2013, which is when the Marketplace's initial enrollment period begins. The notice will include information on eligibility for the Marketplace's new tax credit, which helps lower monthly premiums. Also, the notice will tell you that if you purchase a health plan through the Marketplace, you may lose the employer contribution (if any) to any health plan offered by your employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.

What type of health plans will be available through the Marketplace? All health plans offered through the Marketplace will have limits on cost-sharing and cover a comprehensive package of items and services, which is known as the "essential health benefits" package. In general, the Marketplace will offer four levels of coverage for consumers. The levels are based on an actuarial value (AV) standard that measures the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV value of 70 percent, a consumer would be responsible for 30 percent of the costs for covered benefits. The Marketplace's coverage levels are bronze (AV – 60 percent), silver (AV – 70 percent), gold (AV- 80 percent) and platinum (AV – 90 percent).

How much will a health plan cost through the Marketplace? The premiums for health plans offered on the Marketplace will vary by type of plan and location. Different financial assistance programs will be linked to the Marketplace when enrollment begins, such as Medicaid and the Children's Health Insurance Program.

Also, when enrollment through the Marketplace starts in October 2013, some individuals will be eligible for a new kind of tax credit they can use right away to lower their monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the premium, so eligible individuals pay less out of their own pockets.

Who will be eligible for the Marketplace's premium tax credit? Eligibility for the tax credit depends on your income and family size and your eligibility for minimum essential coverage (such as coverage under your employer's plan). The amount of the credit also depends on how much income your family expects to earn. To be eligible for the tax credit, you must enroll in a health plan through the Marketplace and you:

Must have household income for the year between 100 percent and 400 percent of the federal poverty line for your family size



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May not be claimed as a tax dependent of another taxpayer

Must file a joint return, if married

Cannot be eligible for minimum essential coverage

If you are eligible to enroll in an employer's health plan that meets certain standards, you are eligible for minimum essential coverage. This would make you ineligible for the premium tax credit. An employer's plan does not provide minimum essential coverage if the cost for employee-only coverage is more than 9.5 percent of your income for the year, or if the coverage does not meet the "minimum value" standard set by the health care reform law.

More information on the health care reform law is available at: www.healthcare.gov.

Sources: Department of Labor, Department of Health and Human Services



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